State of South Dakota

SEVENTY-FOURTH SESSION
LEGISLATIVE ASSEMBLY, 1999

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SENATE BILL NO. 234

Introduced by: The Committee on State Affairs at the request of the Governor

FOR AN ACT ENTITLED, An Act to establish criteria for the use of utilization review by health carriers, utilization review organizations, and other contracted entities and for the coverage of emergency services.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. Terms used in this Act mean:

(1) "Adverse determination," a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service is therefore denied, reduced, or terminated;

(2) "Certification," a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness;

(3) "Concurrent review," utilization review conducted during a patient's hospital stay or

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course of treatment;

(4) "Covered benefits" or "benefits," those health care services to which a covered person is entitled under the terms of a health benefit plan;

(5) "Covered person," a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(6) "Director," the director of the Division of Insurance;

(7) "Emergency medical condition," the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy;

(8) "Emergency services," health care items and services furnished or required to evaluate and treat an emergency medical condition;

(9) "Health benefit plan," a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;

(10) "Health care professional," means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law;

(11) "Health care provider" or "provider," a health care professional or a facility;

(12) "Health care services," services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(13) "Health carrier," an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the director, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care

services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services;

(14) "Managed care plan," a plan as defined in subdivisions 58-17-91(3) and 58-18-64(3);

(15) "Network," the group of participating providers providing services to a managed care plan;

(16) "Participating provider," a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier;

(17) "Prospective review," utilization review conducted prior to an admission or a course of treatment;

(18) "Retrospective review," utilization review of medical necessity that is conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment;

(19) "Secretary," the secretary of the Department of Health;

(20) "Stabilized," with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before a person can be transferred;

(21) "Utilization review," an activity as defined in subdivisions 58-17-91(4) and 58-18-64(4);

(22) "Utilization review organization," an entity as defined in subdivisions 58-17-91(5) and 58-18-64(5).

Section 2. This Act applies to a health carrier that provides or performs utilization review

services. The requirements of this Act also apply to any designee of the health carrier or utilization review organization that perform utilization review functions on the carrier's behalf.

Section 3. A health carrier is responsible for monitoring all utilization review activities carried out by, or on behalf of, the health carrier and for ensuring that all requirements of this Act and rules promulgated pursuant to this Act are met. The health carrier shall also ensure that appropriate personnel have operational responsibility for the conduct of the health carrier's utilization review program.

Section 4. A health carrier that conducts utilization review shall implement a written utilization review program that describes all review activities, both delegated and non-delegated, for covered services provided. The program document shall describe the following:

(1) Procedures to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health services;

(2) Data sources and clinical review criteria used in decision-making;

(3) The process for conducting appeals of adverse determinations;

(4) Mechanisms to ensure consistent application of review criteria and compatible decisions;

(5) Data collection processes and analytical methods used in assessing utilization of health care services;

(6) Provisions for assuring confidentiality of clinical and proprietary information;

(7) The organizational structure (e.g. utilization review committee, quality assurance or other committee) that periodically assesses utilization review activities and reports to the health carrier's governing body; and

(8) The staff position functionally responsible for day-to-day program management.

Section 5. A health carrier shall prepare an annual summary report of its utilization review program activities and file the report, if requested, with the director and secretary.

Section 6. A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria, or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request to authorized government agencies including the Division of Insurance and the Department of Health. Qualified health care professionals shall administer the utilization review program and oversee review decisions. Any adverse determination shall be evaluated by an appropriately licensed and clinically qualified health care provider.

Section 7. A health carrier shall comply with the following:

(1) Issue utilization review decisions in a timely manner pursuant to the requirements of this Act;

(2) Obtain all information required to make a utilization review decision, including pertinent clinical information;

(3) Have a process to ensure that utilization reviewers apply clinical review criteria consistently;

(4) Routinely assess the effectiveness and efficiency of its utilization review program;

(5) Have sufficient data systems to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively;

(6) If delegating any utilization review activities to a utilization review organization, maintain adequate oversight, which includes:

(a) A written description of the utilization review organization’s activities and responsibilities, including reporting requirements;

(b) Evidence of formal approval of the utilization review organization program by the health carrier; and

(c) A process by which the health carrier evaluates the performance of the utilization review organization;

(7) Coordinate the utilization review program with other medical management activity conducted by the carrier, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction, and risk management;

(8) Provide covered persons and participating providers with access to its review staff by a toll-free number or collect-call telephone line;

(9) When conducting utilization review, collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency, and duration of services;

(10) May not provide incentives, direct or indirect, in compensation to persons providing utilization review services for a health carrier for these persons to make inappropriate review decisions. Compensation to any such persons may not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

Section 8. For initial determinations, a health carrier shall make the determination within two working days of obtaining all necessary information regarding a proposed admission, procedure, or service requiring a review determination. In the case of a determination to certify an admission, procedure, or service, the carrier shall notify the provider rendering the service by telephone within twenty-four hours of making the initial certification. The carrier shall provide written or electronic confirmation of the telephone notification to the covered person and the provider within two working days of making the initial certification. In the case of an adverse determination, the carrier shall notify the provider rendering the service by telephone within twenty-four hours of making the adverse determination. The carrier shall provide written or electronic confirmation of the telephone notification to the covered person and the provider

within one working day of making the adverse determination.

Section 9. For concurrent review determinations, a health carrier shall make the determination within one working day of obtaining all necessary information. In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone the provider rendering the service within one working day of making the certification. The carrier shall provide written or electronic confirmation to the covered person and the provider within one working day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services. In the case of an adverse determination, the carrier shall notify by telephone the provider rendering the service within twenty-four hours of making the adverse determination. The carrier shall provide written or electronic notification to the covered person and the provider within one working day of the telephone notification. The service shall be continued without liability to the covered person until the covered person has been notified of the determination.

Section 10. For retrospective review determinations, a health carrier shall make the determination within thirty working days of receiving all necessary information. In the case of a certification, the carrier may notify in writing the covered person and the provider rendering the service. In the case of an adverse determination, the carrier shall notify in writing the provider rendering the service and the covered person within five working days of making the adverse determination.

Section 11. Any written notification of an adverse determination shall include the principal reason or reasons for the determination, the instructions for initiating an appeal, grievance, or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale used to make the determination. A health carrier shall provide the clinical rationale in writing for an adverse determination, which shall contain sufficient specificity to

allow the covered person to understand the basis of the adverse determination, to any party who received notice of the adverse determination and who follows the procedures for a request.

Section 12. A health carrier shall have written procedures to address the failure or inability of a provider or a covered person to provide all necessary information for review. If the provider or a covered person does not release necessary information, the health carrier may deny certification.

Section 13. When conducting utilization review or making a benefit determination for emergency services:

(1) A health carrier shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization of such services if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. With respect to care obtained from a non-contracting provider within the service area of a managed care plan, a health carrier shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization of such services if a prudent layperson would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider. Coverage of emergency services required by this section that are obtained from a non-contracting provider shall be at the same benefit level as if the service had been performed by a contracted network provider;

(2) A health carrier shall cover emergency services if the health carrier, acting through a participating provider or other authorized representative, has authorized the provision of emergency services;

(3) If a participating provider or other authorized representative of a health carrier authorizes emergency services, the health carrier may not subsequently retract its

authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on a material misrepresentation about the covered person's health condition made by the provider of emergency services;

(4) Coverage of emergency services is subject to applicable copayments, coinsurance, and deductibles;

(5) For immediately required post-evaluation or post-stabilization services, a health carrier shall provide access to an authorized representative twenty-four hours a day, seven days a week, to facilitate review or otherwise provide coverage with no financial penalty to the covered person.

Section 14. The director may, after consultation with the secretary, promulgate rules pursuant to chapter 1-26 to carry out the provisions of the Act. The rules shall be designed to afford the public timely administration of utilization review, to assure that utilization review decisions are made in a fair and clinically acceptable manner, and to ensure that the public is treated fairly with respect to medical emergencies. The rules may include the following:

(1) Definition of terms;

(2) Timing, form, and content of reports;

(3) Application of clinical criteria as it relates to utilization review;

(4) Written determinations; and

(5) Utilization review procedures.

Section 15. If the director and secretary find that the requirements of any private accrediting body meet the requirements of utilization review as set forth in this Act, the carrier may, at the discretion of the director and secretary, be deemed to have met the applicable requirements.

Section 16. Nothing in this Act applies to health carrier's plans that do not directly or indirectly engage in utilization review or to dental only, vision only, accident only, school

accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed occurrence, or fixed per procedure benefit without regard to expenses incurred.